



June 6, 2022

JAIME PEREZ
74 MERYL COURT
GROTON CT 06340

RE: Jaime Perez
Paid Leave Benefit Case ID: 00353299

Notification of Approval

Reason:	Your Injury or Illness
Type:	Continuous
Date of Leave:	April 10, 2022
Requested Time:	April 10, 2022 - May 10, 2022

Dear Jaime Perez,

Your application for the CT Paid Leave program was filed with us on April 8, 2022. We have determined that you meet the eligibility requirements and are entitled to receive benefits based on the documentation you provided us. We have approved your paid leave benefit case. You should keep this notice for reference throughout the duration of your paid benefit leave. Your employer may request a copy of this decision and/or ask you to send a copy to your leave and disability carrier if you have an open claim with them.

Benefits approved:

Benefit	Absence Start Date	Absence End Date	Weekly Benefit Amount
Connecticut Paid Family and Medical	April 10, 2022	May 10, 2022	$780.00

You must notify us if you apply for or receive any payments from your employer, an insurer, or a government program (like Worker's Compensation, unemployment insurance or Social Security Disability Insurance) for any of the absences you report to us.

- If you receive payments from your employer or a short-term or long-term disability insurer for your absences, it may reduce the amount of benefits you receive from the CT Paid Leave program.
- Additionally, if you receive benefits from the CT Paid Leave program and later receive Worker's Compensation benefits, unemployment insurance, Social Security Disability Insurance or other similar government-funded benefits, you must agree to pay back CT Paid leave benefits you received.

Failure to accurately report hours or earnings or any other change in circumstances that would reduce the amount of benefits you received may result in penalties, including repayment of benefits paid plus interest as well as the possibility of being disqualified from applying for benefits from the CT Paid Leave program for up to 2 years.

You are required to report any change in circumstances that may affect the duration of your leave, your eligibility for benefits, or the amount of your benefit payment within seven (7) days. You may do so by calling Aflac at (877) 499-8606.

Should you need to extend your leave, and you have entitlement remaining, please have the attached Certification for Serious Health Condition updated. You will be responsible for having this information completed and submitted to your Case Manager for consideration.

How to send us forms and information:

You have the following options on how you can send us forms and information that we need:

- To take a photo or scan and upload it in to your paid leave benefit case, visit **https://ctpaidleave.org/** and register/login; or
- Fax to (888) 485-0973; or
- You can email it to us at **CTPFL@Aflac.com**; or
- Mail it to us at:

  Aflac CTPFML Administration
  PO Box 84077
  Columbus GA 31908-4077

Choose your communication preferences:

Visit https://ctpaidleave.org/ to register/login, click on the **Personal Info** tile-click on **Manage Your Account**, and then click on **Notifications**:

- Update your **Communication Preferences**, click the gear icon and follow the prompts to set your preference to US Mail (default) or Email.
- Update your **Text Messaging Preferences**, click on the gear icon and follow the prompts to set your preferences.

Looking for more information?

Getting helpful information during your time away from work is simple. Our portal allows you to check the status of your paid leave benefit case, upload documents and manage your communication preferences including text notification. Get started today by visiting https://ctpaidleave.org/ to register/login. Use Google Chrome to ensure you get the best experience.

Our Customer Care Advocates are available to answer any questions you may have. You can contact us Monday through Friday at (877) 499-8606 from 8:00 am to 8:00 pm EST.

Sincerely,

Racquel B.

Aflac Connecticut Paid Leave Administration Team *

Enclosures:

Certification for Serious Health Condition

** Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*

Connecticut Paid Leave

Certification for Serious Health Condition



Aflac CTPFML Administration
PO Box 84077
Columbus GA 31908-4077

Toll Free: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Applicant Information

First Name: Jaime	Last Name: Perez	Case Number: 00353299

Last 4 Digits of SSN:	Date of Birth:

Address: 74 Meryl court	City: Groton	State: Connecticut	Zip Code: 06340

Cell Number:	Phone Number:	Work Number:

Employer Information

Employer Name:	Date of Hire:
Address:	

City:	State:	Zip Code:

Job Title:	Job Duties:

What is the Paid Leave for?

☐ My Own Serious Health Condition ☐ Pregnancy ☐ Organ/Bone Marrow Donation

Health Care Provider Information

Health Care Provider's Name:

Health Care Provider's Business Address:

City:	State:	Zip Code:

Type of Practice/Medical Specialty:

Certificate license number and state:

Telephone:	Fax:	Email:

Part A: Medical Information (To Be Completed By Health Care Provider)

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under Connecticut Paid Leave (CT PL).

Limit your response to the medical condition(s) for which the employee is seeking CT Paid Leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For CT PL purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

** Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*

Applicant First Name:	Applicant Last Name:	Case Number:
Jaime	Perez	00353299

Part A: Medical Information (continued)

1. State the approximate date the condition started or will start: ____________________

2. Provide your best estimate of how long the condition lasted or will last: ____________________

3. Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ Inpatient Care: The patient ☐ has been / ☐ is expected to be admitted for an overnight stay in a hospital, hospice or residential medical care facility on the following dates: ____________________

☐ Incapacity plus Treatment: *(e.g. outpatient surgery, broken leg)*

Due to the condition, the patient ☐ has been / ☐ is expected to be incapacitated for *more than* three consecutive, full calendar days from ____________ *(mm/dd/yyyy)* to ____________ *(mm/dd/yyyy).*

The patient (☐ was / ☐ will be) seen on the following date(s): ____________________

____

And, the condition ☐ has / ☐ has not also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication *(other than over-the-counter) or therapy requirement special equipment).*

☐ Pregnancy: The condition is pregnancy. Expected date of delivery: ____________ *(mm/dd/yyyy)*

☐ Chronic Conditions: *(e.g. asthma, migraine headaches)* It is medically necessary for the patient receive treatment from a healthcare provider for this condition at least 2 times per year. Please provide the dates of the last two appointments and the next scheduled appointment.

Last two appointments: ____________ *(mm/dd/yyyy)*, and ____________ *(mm/dd/yyyy)*

Next scheduled appointment: ____________ *(mm/dd/yyyy)*

☐ Permanent or Long Term Conditions: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ Conditions requiring Multiple Treatments: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments. Please provide the frequency: ____________________

____

☐ Organ/Bone Marrow Donor: Due to this condition, the patient will require medical care on the following dates and will be out of work: ____________________

____

4. Briefly describe other appropriate medical facts related to the condition(s) for which the applicant seeks CT Paid Leave benefits that demonstrate the individual has a serious health condition as defined above.

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Applicant First Name: Jaime	Applicant Last Name: Perez	Case Number: 00353299

Part B: Amount of Leave Needed (To be completed by Health Care Provider)

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" will not be sufficient to determine CT Paid Leave coverage.

1. Due to the condition, the patient needed/will need time off from work for **planned medical treatment**(s) (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)*. Please list the applicable dates for treatment: ____

   ____

2. Due to the condition, the patient was/will be **referred to other health care provider(s**) and will need time off from work for evaluation or treatment.

   State the nature of such treatments *(e.g. cardiologist, physical therapy)*: ______________________

   ____

   Provide your **best estimate** of the beginning date ______________ *(mm/dd/yyyy)*; and the end date ______________ *(mm/dd/yyyy).*

   Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)* ____

3. Due to the condition, it was/will be medically necessary for the employee to work a **reduced schedule**.

   Provide your **best estimate** of the reduced schedule the employee is able to work:

   From ______________ *(mm/dd/yyyy)* to ______________ *(mm/dd/yyyy)* the employee is able to work ______________________ *(e.g. 5 hours/day, up to 25 hours a week).*

4. Due to the condition, the patient was/will be **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

   Provide your **best estimate** of the beginning date ______________ *(mm/dd/yyyy)* and the end date ______________ *(mm/dd/yyyy)* for the period of incapacity.

5. Due to the condition, it was/will be medically necessary for the applicant to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

   Over the next 6 months, episodes of incapacity are estimated to occur ______________ times per ☐ day / ☐ week / ☐ month and are likely to last approximately ______________ ☐ hours / ☐ days per episode.

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Health Care Provider Signature & Credentials	Date

CTPL-0004 (07-2021)

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